Opioid Analgesic Treatment Worksheet

☐ **Aetna Better Health of Louisiana**
Fax: 1-844-699-2889
www.aetnabetterhealth.com/louisiana/providers/pharmacy

☐ **Amerigroup**
Fax: 1-888-346-0102
www.myamerigroup.com/la/pages/medicaid.aspx

☐ **AmeriHealth Caritas Louisiana**
Fax: 1-855-452-9131
www.amerihealthcaritasla.com/pharmacy/index.aspx

☐ **Fee for Service (FFS) Louisiana Legacy Medicaid**
Fax: 1-866-797-2329
www.lamedicaid.com

☐ **LA Healthcare Connections**
Fax: 1-866-399-0929
www.louisianahealthconnect.com/for-members/pharmacy-services/

☐ **UnitedHealthcare**
Fax: 1-866-940-7328
www.uhccommunityplan.com/health-professionals/la/pharmacy.html

Please fax the completed form to the appropriate plan using the designated fax number provided above.

Please note: An approval is not a guarantee of payment. All edits will apply when medication is processed at point-of-sale. Payment on a claim will only be made when the claim is billed correctly and all conditions for payment are met.

Recipient Name:	FFS / MCO ID #:	Recipient DOB:	
EPSDT Support Coordinator (Name/Address): *(optional)*	Medication Allergies:	Recipient Weight (kg):	Recipient Height (ft/in):
Prescriber Name:	Prescriber Specialty:	Medicaid Provider ID # or NPI#:	
Call-Back Phone#:	Office Fax#:	Office Contact:	

DRUG INFORMATION (one drug per request)

Drug Name / Dosage Form:_____Strength:_____

This medication is a PREFERRED / NON-PREFERRED Agent. (CIRCLE ONE)

If request is for a non-preferred agent, list preferred agents tried:_____
If not, explain why recipient is unable to use a preferred agent:_____
_____
_____

Is this request for medication prescribed for treatment of pain related to cancer, palliative care, or end-of-life care? _____Yes _____No

IF NO, SKIP THIS SECTION AND CONTINUE.

If yes, FOR FFS AND AMERIHEALTH CARITAS, this form is not required. Pharmacist must enter diagnosis code at Point of Sale.
If yes, FOR ALL OTHER PLANS, STOP HERE AND complete all information above this section AND state diagnosis:_____
AND prescriber's signature:_____AND fax to appropriate plan above.

Requested medication is short-acting / long-acting. (CIRCLE ONE) Directions:_____

Quantity Requested: _____ DOES THIS EXCEED THE MAXIMUM QUANTITY LIMIT PER DAY? YES / NO (CIRCLE ONE)

Request is for: _____Initiation of therapy _____Continuation of Therapy

For continuation of therapy, is the dose currently being tapered? _____Yes _____No

If no, explain: _____

Recipient's current *CUMULATIVE* MORPHINE EQUIVALENT DOSE (MED)/DAY: _____ (include MED for medication being requested)

Note: The Louisiana Prescription Monitoring Program (PMP) provides the cumulative MED for all of the recipient's controlled medications. Information is current through the previous day (the day before the PMP is accessed).

DOES THIS EXCEED THE MAXIMUM MED ALLOWED PER DAY? YES / NO (CIRCLE ONE)

TREATMENT INFORMATION

This medication is being used for: _____acute condition _____chronic condition (check one only)

Is this medication being used for moderate to severe neuropathic pain or fibromyalgia? _____Yes _____No

Is this medication being used for postoperative pain? _____Yes _____No If yes, date of surgery:_____

Diagnoses for which the opioid is prescribed (include primary and secondary diagnoses applicable to this request, ICD code and description):

Diagnosis:_____ Diagnosis:_____
Date of Diagnosis:_____ Date of Diagnosis:_____

List other **treatments that have been tried or are currently being given** for this condition, both pharmacological and non-pharmacological:

Pharmacological Treatments

Drug / Strength	Directions	Start Date / End Date (or Current)	Reason for Discontinuation (if applicable)

Non-pharmacological Treatments

Treatment	Start Date / End Date (or Current)

For **quantity limit override OR MED override**, explain in detail the need for requested quantity/MED: _____
_____
_____
_____

PRESCRIBER ATTESTATION

Please indicate YES/True or NO/False for each of the following attestations. Explanation is required for each 'NO/False' answer in order for the request to be considered for approval. For short-acting opioids, complete A – G; for long-acting opioids, complete A – L.

	YES (True)	NO (False)	THE PRESCRIBER ATTESTS TO THE FOLLOWING:
SHORT AND LONG-ACTING OPIOIDS			A. A complete **assessment** for pain and function was performed for this patient and **documentation is attached**.
			B. The patient has been **screened for substance abuse / opioid dependence** and **documentation is attached**. *(Not required for recipients in long-term care facility)*
			C. The **PMP** (Prescription Monitoring Program) will be accessed **each** time a controlled prescription is written for this patient.
			D A **treatment plan** which includes current and previous goals of therapy for both pain and function has been developed for this patient.
			E. **Criteria** for failure of the opioid trial and for stopping or continuing the opioid has been established and explained to the patient.
			F. **Benefits and potential harms** of opioid use have been discussed with this patient. In addition, if the patient has concurrent comorbidities or is taking medications that could potentially cause drug-drug interactions, an assessment of increased risk for respiratory depression has been completed and discussed with the patient. The risk of combining opioids with other central nervous system depressants, such as benzodiazepines, alcohol, or illicit drugs such as heroin, has also been specifically addressed. The level of risk for opioid abuse/overdose with the dose/duration prescribed to the patient has also been discussed.
			G An **Opioid Treatment Agreement** signed by both the patient and prescriber is on file. *(Not required for recipients in long-term care facility)*

LONG-ACTING OPIOIDS	YES (True)	NO (False)	THE PRESCRIBER ATTESTS TO THE FOLLOWING:
			H The patient requires continuous **around the clock** analgesic therapy for which alternative treatment options have been inadequate or have not been tolerated.
			I. Patient previously utilized at least two weeks of short-acting opioids for this condition. Please enter drug(s), dose, duration and date of trial in *Pharmacological Treatment Section* on page 1.
			J. Medication has **not** been prescribed to treat acute pain, mild pain, or pain that is not expected to persist for an extended period of time.
			K. Medication has **not** been prescribed for use as an as-needed (PRN) analgesic.
			L. Prescribing information for requested product has been **thoroughly reviewed** by prescriber.

*IF NO FOR **ANY** OF THE ABOVE (A-L), PLEASE EXPLAIN:*

THIS SECTION APPLIES TO **AETNA BETTER HEALTH OF LOUISIANA** RECIPIENTS ONLY.

Aetna

Does the Opioid Treatment Agreement include All of the following? _____Yes _____No

- Consequences of lost medication or taking more than prescribed
- Consequences of obtaining controlled substances from other prescribers
- Member agreement to only use one pharmacy

Is the request for Nucynta ER for the treatment of **diabetic peripheral neuropathy**? _____Yes _____No

- If yes, has the patient had an inadequate response or intolerance to duloxetine AND tramadol AND at least one additional formulary medication (e.g., gabapentin, amitriptyline, nortriptyline, or topical capsaicin)? _____Yes _____No
- If yes, were the trials of the formulary agents at least 4 weeks and at maximum tolerated doses? _____Yes _____No

Worksheet required for all requests / approvals. For questions only, please call 1-855-242-0802.

THIS SECTION APPLIES TO **AMERIGROUP** RECIPIENTS ONLY.

Amerigroup

For long-acting opioids, the following must also be met:

☐ Yes ☐ No	Has individual had a trial and inadequate response or intolerance to two preferred long-acting agents (preferred agents – morphine sulfate ER [specifically, generic MS Contin], fentanyl patch)?
☐ Yes ☐ No	Has individual completed titration and is already maintained on a stable dose of the requested drug?
☐ Yes ☐ No	Are the preferred long-acting opioids not acceptable due to concomitant clinical situations, such as but not limited to known hypersensitivity to any ingredient which is not also in the requested non-preferred agent?
☐ Yes ☐ No	Does individual require a non-preferred abuse deterrent agent (OxyContin, Hysingla ER, Targiniq ER, Embeda, MorphaBond, and Xtampza ER, Troxyca ER, Vantrela ER, Arymo ER) based upon a history of substance abuse disorder OR individual's family member or household resident has active substance abuse disorder or a history of substance abuse disorder?
☐ Yes ☐ No	Does individual require Butrans (buprenorphine transdermal patch) or Belbuca (buprenorphine buccal film) due to concern for abuse or dependence with pure opioid agents?

Amerigroup

Approval duration for both short-acting and long-acting opioids, if criteria above are met:

Palliative care and cancer pain: 12 months

All other pain conditions:

Initial request: 3 months

Maintenance requests: 6 months

For questions, please call 1-800-454-3730.

THIS SECTION APPLIES TO **AMERIHEALTH CARITAS** LOUISIANA RECIPIENTS ONLY.

AmeriHealth Caritas

AmeriHealth Caritas

AmeriHealth Caritas

Please note:

For short-acting opioids, if these criteria are met, the request will be approved with up to 3 months duration. For long-acting opioids, if these criteria are met, the request will be approved with up to 6 months duration. Also, if this request for is for a medication prescribed for treatment of pain related to cancer, palliative care, or end-of-life care, no further review is necessary as it will pay at POS with appropriate diagnosis code.

1. If this request is for a non-formulary opioid drug, patient must also try and fail up to 3 formulary alternatives before approving non-formulary opioids. If yes, list formulary agents tried:_____

2. For requests to exceed the quantity limits for **short-acting opioids**:
   a. Has the patient tried and failed (or is the patient currently using) 2 or more of the following:
      Non-Opioid Formulary Treatment Alternatives for Fibromyalgia or Peripheral Neuropathy
      Antidepressants: Amitriptyline, Nortriptyline, Duloxetine, Venlafaxine, Savella
      Anticonvulsants: Gabapentin capsules, Carbamazepine
      Muscle Relaxants: Baclofen, Cyclobenzaprine, Methocarbamol, Tizanidine tablets
      NSAIDs: Aspirin, Celebrex (PA required), Diclofenac, Etodolac, Ibuprofen, Indomethacin, Meloxicam, Nabumetone (PA required), Naproxen, Salsalate, Sulindac
      Non-Opioid Analgesics: Acetaminophen
      If yes, list alternatives tried:_____
      Non-Opioid Formulary Treatment Alternatives for Back Pain or Other Generalized Pain
      Muscle Relaxants: Baclofen, Cyclobenzaprine, Methocarbamol, Tizanidine tablets
      NSAIDs: Aspirin, Celebrex (PA required), Diclofenac, Etodolac, Ibuprofen, Indomethacin, Meloxicam, Nabumetone (PA required), Naproxen, Salsalate, Sulindac
      Non-Opioid Analgesics: Acetaminophen
      If yes, list alternatives tried:_____
   b. Explain medical necessity:
      _____
      _____

3. For requests for **Vicoprofen**:
   a. Diagnosis of acute pain? _____Yes _____No
   b. Documented trial and failure or intolerance to at least three of the following medications: oxycodone/acetaminophen, hydrocodone/acetaminophen, acetaminophen/codeine, morphine and hydromorphone? _____Yes _____No

4. For requests for **long-acting opioids** and/or to exceed the quantity limits for **long-acting opioids**:
   Explain medical necessity:_____
   _____
   _____

5. For requests for **Oxycontin Extended Release**:
   a. Documented trial and failure or intolerance to sustained-release morphine sulfate? _____Yes _____No
   b. Documented trial and failure or intolerance to fentanyl patches? _____Yes _____No

6. For requests to exceed the **Morphine Equivalent Dosing (MED) limits**:
   a. Explain medical necessity:_____
   b. The prescriber attests to titration of dose requested: ***If using for breakthrough pain, dose requested is 10-20% of total daily analgesic dose*** _____Yes _____No

7. Physician address:
   (Street)_____
   (City)_____(State)_____(Zip)_____

For questions, please call 1-800-684-5502.

THIS SECTION APPLIES TO **LA LEGACY FFS MEDICAID** RECIPIENTS ONLY.

FFS

Is the patient currently a resident in a long-term care facility? _____Yes _____No
If yes, provide facility name, phone number, and contact person: _____

For questions, please call 1-866-730-4357.

THIS SECTION APPLIES TO **LA HEALTHCARE CONNECTIONS** RECIPIENTS ONLY.

LA Healthcare Connections

1. If this is a non-formulary request, member must try and fail 2 formulary alternatives before non-formulary request can be considered for approval.
2. Short Term Therapy (up to a total 90 days therapy within 180 days): Member may only have 2 concurrent opioids and total opioid dose may not exceed 120 morphine equivalent dose (MED) per day. **State Mandated quantity/days' supply limits apply. **
3. Long Term Therapy (excess of 90 days therapy within 180 days): A. Member must have failed at least 2 non-opioid ancillary treatments (NSAIDS, APAP, anticonvulsants, antidepressants, etc.) B. Immediate release must be failed before extended release can be approved. C. Member may only have 2 concurrent opioids with therapy consisting of one short acting and one long acting opioid. D. Total opioid dose may not exceed 120 MED per day.
   If criteria are met, chronic pain approval duration=3 months and cancer pain, palliative care approval duration = 12 months
   **State Mandated quantity/days' supply limits apply. **
4. Request for > 2 opioid analgesics concurrently- Cancer pain/Palliative care/Sickle cell crisis - **A.** Opioid therapy must be prescribed by a specialist for sickle cell crisis pain/cancer pain/palliative care; **B.** Prescriber will be requested to discontinue opioid analgesic to meet the two (2) or less opioid limit by the following methods: 1. Addition of an extended release opioid analgesic, if not present; 2. Upward titration of existing opioids within plan allowed quantity limits; **C.** Prescriber must provide documented clinical rationale for the use of > 2 opioid analgesics concurrently instead of adding an extended release opioid or titrating/discontinuing current opioid analgesics.
   ** If criteria are met, approval duration=6 months. **
   **State Mandated quantity/days' supply limits apply. **

For questions, please call 1-888-929-3790.

THIS SECTION APPLIES TO **UNITED HEALTHCARE** NON-CANCER PAIN RECIPIENTS ONLY.

United Healthcare

Please provide defined **treatment goals**, including estimated duration of treatment:

- Treatment goals: _____
- Estimated duration of treatment: _____
- Does the treatment plan include concurrent use of a **non-opioid analgesic and/or non-pharmacologic intervention**? __Yes __No
- List other treatment interventions:

_____
_____

Does the total dose of opioid therapy **exceed the Louisiana plan quantity limit of 120 MED**? _____Yes _____No

- If "Yes", did you consult a pain specialist, defined as a prescriber with a pain management specialty designated by the American Board of Anesthesiology, or one of the following specialties: hematology, oncology, anesthesiology, neurology, or psychiatry? _____Yes ____ No
- Document prescriber specialty and total daily dose: _____

Has the patient demonstrated meaningful improvement in pain and function using a validated instrument (e.g. Brief Pain Inventory)?
_____Yes _____No

- Score: _____
- Instrument used: _____

Rationale for not tapering and discontinuing opioid treatment:

_____
_____
_____

If the request **exceeds the quantity limit**, document rationale for the requested quantity and/or for exceeding the Louisiana Health Plan approved limit: _____

If the request is for **Oxymorphone ER-non crush resistant (generic) or Zohydro ER**, is there a clinical reason why a preferred agent cannot be used (preferred long-acting agents: morphine sulfate controlled release tablets (generic of MS Contin), fentanyl transdermal)?
_____Yes _____No

- If yes, explain: _____

If the request is for a **non-preferred agent**, is there a clinical reason why a preferred agent cannot be used (Preferred agents: morphine sulfate controlled release tablets (generic of MS Contin) and fentanyl transdermal. Preferred agents with Step Therapy: oxymorphone ER non-crush resistant (generic) and Zohydro ER)? _____Yes _____No

- If yes, explain: _____
  _____

	If the request is for **tramadol ER capsules or tablets**, is there a clinical reason why preferred alternatives cannot be used (preferred alternatives include opioid and non-opioid analgesics): • _____If yes, explain: _____ • _____If no, list preferred alternatives previously tried (document dose, dates of therapy and rationale for discontinuation): _____ If the medication is being prescribed for **<u>moderate to severe neuropathic pain or fibromyalgia</u>**, complete the two questions below: • Has the patient not exhibited an adequate response to eight weeks of treatment with gabapentin titrated to a therapeutic dose? _____Yes ____No If "Yes", document duration and date of trial: _____ • Has the patient not exhibited an adequate response to at least six weeks of treatment with a tricyclic antidepressant titrated to a therapeutic dose? _____Yes _____No If "Yes", document duration and date of trial: _____ If the medication is being prescribed for **<u>post-operative pain</u>**, complete the two questions below: • Is the patient already receiving chronic opioid therapy prior to surgery? _____Yes _____No • Is the post-operative pain expected to be moderate to severe and persist for an extended period of time? _____Yes _____No For questions, please call 1-800-310-6826.

Opioid overdose reversal medications are a covered benefit. Prior authorization is not required for some products. CDC guidelines recommend offering naloxone to patients at increased risk of overdose, defined as: history of overdose or substance use disorder, doses <u>≥</u> 50 MED /day, or concurrent use with benzodiazepines. Please refer to the appropriate FFS/MCO Preferred Drug List for preferred products.

I certify that the benefits of opioid treatment for this patient outweigh the risks of treatment and that the information provided herein is true and accurate to the best of my knowledge and may be subject to a routine audit requesting the medical information necessary to verify the accuracy of the information provided.

Prescriber's Signature: _____Date:_____